

OFFICE USE ONLY
IM Worker _____ Date _____ Case Number _____
IM Supervisor _____ Date _____ Related Case Number(s) _____
TANF Status: () NA () RA () RO () TR Date Registered _____

SECTION I

APPLICANT: Please use a pen to complete this form carefully and accurately. IF YOU ARE NOT SURE OF ANY ANSWER, LEAVE THE SPACE BLANK. If you have any questions, ask the county welfare worker.

DO NOT WRITE IN THE SHADED BOXES

1. For Which Program(s) Do You Wish to Apply or Reapply?

- () TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) () AFDC-ONLY MEDICAID () GENERAL ASSISTANCE
() NJ SNAP PROGRAM () REFUGEE RESETTLEMENT PROGRAM
() EMERGENCY ASSISTANCE () KINSHIP CARE SUBSIDY PROGRAM

I (we) understand that as a condition of WFNJ eligibility, I (we) shall be required to continuously and actively seek employment in an effort to gain self-sufficiency.

I (we) understand that as a condition of WFNJ eligibility, I (we) shall be required to register for work with New Jersey One Stop Career Center.

2. Are you willing to work? [] YES [] NO

3. Applicant's name: _____ (LAST) (FIRST) (MI) (MAIDEN)

4. Resident Address: The place where you actually live:

_____(NUMBER AND STREET OR RFD) (CITY) (STATE) (ZIP CODE)

Address where your mail goes if different from your resident address above.

_____(P.O. BOX, STREET ADDRESS, OR RFD) (CITY) (STATE) (ZIP CODE)

Your telephone number: HOME () _____ WORK () _____ CELL () _____

5. New Jersey Residence (NOT APPLICABLE FOR NJ SNAP PURPOSES)

RESIDENCE VERIFICATION

Do you plan to continue living in New Jersey? [] YES [] NO

If "NO", EXPLAIN: _____

6. You can authorize a person(s) outside your household to apply for NJ SNAP or GA for you, to obtain NJ SNAP benefits or GA benefits, or to use NJ SNAP benefits to purchase food for you. If you are eligible for NJ SNAP benefits, the individual you designate will receive a FAMILIES FIRST EBT card that he or she can use to buy your food. If you wish to designate such a person, complete the following information:

Table with 5 columns: Name of Authorized Representative, Date of Birth, Address, SSN (Optional), Telephone Number

QUESTIONS 7 and 8 BELOW - FOR NJ SNAP APPLICANTS ONLY

7. You have the right to file an application for NJ SNAP immediately by providing your name, address, signature and date signed. If you are determined eligible, your benefits will be paid from that date. (If you file an application and provide all the necessary information about your circumstances and are found eligible, you can get NJ SNAP within 30 days of the date the NJ SNAP office receives your application.)

8. If you have very little income and resources, you may be eligible for expedited benefits (to be received within 7 days). YOUR ANSWERS TO THE FOLLOWING QUESTIONS WILL DETERMINE IF YOU QUALIFY FOR THIS SERVICE:

- (a) Is your household's total gross monthly income less than \$150.00 and your household's total liquid resources (such as cash or checking/savings accounts) \$100.00 or less? [] YES [] NO
(b) Is your household's monthly rent or mortgage plus utilities more than your household's total monthly gross income plus total liquid resources? [] YES [] NO
(c) Is your household a migrant or seasonal farm-working household with little or no income? [] YES [] NO

OFFICE USE ONLY

CATEGORICAL ELIGIBILITY:

Does everyone in the household receive Public Assistance (WFNJ) or SSI? [] YES [] NO

9. _____ (SIGNATURE OF PERSON INITIATING APPLICATION) (DATE SIGNED)

Name	Social Security Number	Birthdate _____	Relationship To Applicant	Sex (F) or (M)	Race/Ethnicity	Legal Alien & BCIS Status	Marital Status	Grade and School	
		Birthplace							
Other Applicant									PA
Last									NJ SNAP
First m.i									MA
For Office Use Only									
Other Applicant									PA
Last									NJ SNAP
First m.i									MA
For Office Use Only									
Other Applicant									PA
Last									NJ SNAP
First m.i.									MA
For Office Use Only									
Other Applicant									PA
Last									NJ SNAP
First m.i.									MA
For Office Use Only									
Other Applicant									PA
Last									NJ SNAP
First m.i.									MA
For Office Use Only									

11. List Names of Aliens/Non-Citizens in Your Household

NAME	DATE OF ENTRY/ COUNTRY OF ORIGIN	REGISTRATION #	SPONSOR NAME/ RESETTLEMENT AGENCY	SPONSOR/ RESETTLEMENT AGENCY ADDRESS	DATE APPLIED FOR CITIZENSHIP	SPONSOR INCOME

12. List Other Persons in the Home not Listed Above (Include Roomers/Boarders)

NAME	RELATIONSHIP TO APPLICANT

12a. List an Emergency Contact Person (GA Cases Only) _____.

Phone # _____ Address _____.

13. Expectant Mother's Name _____ Expected Date of Birth _____

Doctor's Name _____ Doctor's Address _____

14. What is the main language spoken in your home? _____.

15. Do you or any member of the applicant household receive or have you received TANF in New Jersey or any other state, territory, or General Assistance (GA) in New Jersey since April 1997?			[] Yes [] No
Individual Receiving Assistance	Type of Assistance	When	Assistance Provider

16. Are you or any member of your household a fleeing felon or in violation of a condition of parole or probation imposed by a Federal or State court?		[] Yes [] No
Individual Fleeing or in Violation	Fleeing From	

17. Have you or any member of your household been convicted of fraudulently receiving means tested benefits in two or more places at the same time?			[] Yes [] No
Individual Convicted of Fraud	Where Fraud Occurred	When	What Benefits

18. Since August 22, 1996, have you or any member of your applicant household committed and been convicted of possession, use or distribution of a controlled substance, which is an indictable offense? Applies to GA only			[] Yes [] No
Individual Committing Offense	Type of Offense	Where Did Offense Occur	

19. If you were convicted of an indictable offense for possession or use, have you enrolled in or completed a Department of Health and Senior Services licensed or approved residential drug treatment program?		[] Yes [] No
Individual Receiving Treatment	Treatment Facility	Date of Treatment

19. a. If you have not enrolled in or completed a Department of Health and Senior Services licensed or approved residential drug treatment program, what is the reason?

_____.

20. Has anyone in the household voluntarily quit a job?

In the last 90 days for WFNJ [] YES [] NO If YES, Who? _____.

In the last 60 days for NJ SNAP [] YES [] NO If YES, Who? _____.

If YES, Why? _____.

21. Is anyone in your household on strike? [] YES [] NO If YES, Who? _____.

22. What was the last date of employment? _____.

22a. What have you been doing since your last employment? _____.

_____.

23. For WFNJ purposes only, list all employment for each person applying for assistance in the last 3 years, starting with the most recent.

Name	Name of Employer	Address of Employer	Start Date	End Date

24. Does any member of the applicant household expect any change in circumstances in the near future, such as a change in income; household size; change in residence; shelter costs; or the purchase or sale of an automobile?
 YES **NO** If **“YES”**, What changes: _____

25. EARNED INCOME: Do you or anyone living with you get money from working, baby-sitting, your own business, odd jobs, selling, or other earned income? **YES** **NO** If **“YES”**, provide the following information for each person:

LAST NAME FIRST NAME						
HOURS PER WEEK						
HOW OFTEN PAID						
EMPLOYER'S NAME AND ADDRESS OR "SELF" IF SELF-EMPLOYED						
PAY (BEFORE ANY PAID DEDUCTIONS) GROSS AMOUNTS AND DATES	DATE	AMOUNT	DATE	AMOUNT	DATE	AMOUNT

26. CHILD/ADULT CARE: Did anyone included in your welfare or NJ SNAP household pay for child care or adult care because of a job, going to school, or looking for work? **YES** **NO** If **“YES”**, who was cared for? (List Below)

NAME OF CHILD/ADULT	CARE PROVIDED BY (PERSON)	DAYS PER WEEK	HOURLY RATE	TOTAL DAYS	ACTUAL AMOUNT PAID/ BY WHOM

VERIFICATIONS

27. CHILD SUPPORT: Are you legally obligated to pay or provide child support to a child outside of your household?
 YES **NO** If “**YES**”, complete the following information: (Include payments for child support arrearages, as long as you are legally obligated to pay them.)

TO WHOM	ADDRESS	AGE OF CHILD	MO. AMOUNT PAID/ PROVIDED	COURT ORDER NUMBER

28. HEALTH INSURANCE: Who is covered by health insurance? **IF NONE, CHECK () HERE.**

LAST NAME, FIRST NAME	INSURANCE COMPANY	POLICY NUMBER	POLICY HOLDER

29. Does an absent spouse have medical or health insurance coverage for you? **YES** **NO** If “**YES**”, what insurance? _____

30. Does any absent parent have medical or health insurance coverage for any of the children for whom you are applying? **YES** **NO** If “**YES**”, what insurance, and for whom? _____

31. Have you or your household members applied for other Medicaid programs? If “**YES**”, which program? _____ Date you applied _____

32. OTHER INCOME: Do you or anyone included in your welfare or NJ SNAP household (including stepparents) receive or applied for any of the following: **YES** ___ **NO** ___ **IF YES, CHECK ALL THAT APPLY.**

<input type="checkbox"/>	Unemployment Insurance	<input type="checkbox"/>	Income from Property Rent	<input type="checkbox"/>	Workers' Compensation
<input type="checkbox"/>	Veterans' Benefits	<input type="checkbox"/>	Income from Roomer(s) and/or Boarders	<input type="checkbox"/>	Union/Pension Benefits
<input type="checkbox"/>	Social Security/Railroad Retirement	<input type="checkbox"/>	Income from Relative, Friend, Lodges or Unions	<input type="checkbox"/>	Child Support
<input type="checkbox"/>	Supplemental Security Income (SSI)	<input type="checkbox"/>	Income Tax Refund or Earned Income Credit	<input type="checkbox"/>	Allotment Check from a Serviceman
<input type="checkbox"/>	Disability Payments	<input type="checkbox"/>	Foster Care Payments	<input type="checkbox"/>	General Assistance
<input type="checkbox"/>	Subsidized Adoption	<input type="checkbox"/>	Trust Fund	<input type="checkbox"/>	Training Allowance
<input type="checkbox"/>	Interest/Dividends from Stocks, Bonds, Bank Accounts, etc.	<input type="checkbox"/>	Lump Sum Payments (from Retroactive Benefits, Money from Lawsuits, etc.)	<input type="checkbox"/>	Student Loans, Grants, Scholarships, or Stipends
<input type="checkbox"/>	Annuity Benefits (Include Life Insurance Dividends)	<input type="checkbox"/>	Lump Sum Earnings, Winnings, or Gifts	<input type="checkbox"/>	Supplemental Work Support
<input type="checkbox"/>	DYFS Relative Care Permanency Support	<input type="checkbox"/>	DYFS Legal Guardianship Subsidy Programs	<input type="checkbox"/>	Other Income, such as, alimony (Specify):

Give the following information for the items checked above:

Last Name, First Name	Source of Income	Dates Received	Total Amount

VERIFICATIONS

33. RESOURCES: (Does apply to NJ SNAP households not eligible for expanded categorical eligibility) Do you or anyone living with you have cash, checking, or savings accounts, stocks, bonds, C.D.'s, IRA's/Keogh, mutual funds, trust funds, U.S. Savings Bonds, Christmas/vacation or other club savings accounts, Credit Union membership, money or valuables in a safe deposit box, notes or contracts of value, ownership of mortgages or other resources? [] **YES** [] **NO**

Person Who Owns Resource	What is the Resource?	Where is the Resource?	How Much is the Resource Worth?

VERIFICATIONS

34. List all vehicles owned by persons in the applicant household. Include all types of transportation such as cars, vans, tractor trailers, pick-up trucks, trailers, motor homes, motorcycles, boats, etc. **IF NONE, CHECK () HERE.**

Owner's Name	Model/Style	Year/Make	Use	Kelley Bluebook Value

35. Do you or does anyone living with you own any land or real estate other than the house you live in? [] **YES** [] **NO**
 If "YES", explain: _____

36. Did anyone trade, give away, transfer or sell real or personal property (including stocks):					
For TANF and GA purposes within the past 12 months?					[] YES [] NO
For NJ SNAP purposes within the past 3 months?					[] YES [] NO
What was sold, given away, etc.?	By Whom?	To Whom?	Date of Gift or Sale?	Total Market Value	Amount Received

37. Do you, or anyone included in your applicant household, have any pending claims such as lawsuits, divorce, settlements, inheritance, accident claims, sale of property, other claims, or does anyone owe you or them money? [] **YES** [] **NO**
 If "YES", explain: _____

DATE WFNJ-10D COMPLETED _____ . (Does not apply to NJ SNAP only clients)

38. Does anyone in the applicant household have: **(Does not apply to NJ SNAP)**

(a) Part or full ownership of valuable personal property such as jewelry, coin/stamp collections, furs, etc.?

[] **YES** [] **NO** If "YES", Explain _____

(b) A burial plot or arrangement ? [] YES [] NO If "YES", VALUE _____.

NJ SNAP AND GA

SHELTER INFORMATION: To be completed if household is applying for participation in the NJ SNAP Program and/or GA.

39. Does anyone outside of the household pay or assist with payments of any household expenses? [] YES [] NO
If "YES", complete below:

TYPE OF SHELTER EXPENSE	PAID TO WHOM	PAID BY	AMOUNT PAID	HOW OFTEN BILLED

40. **SHELTER COSTS** (List household expenses for the following:)

SHELTER EXPENSE	AMOUNT PAID	HOW OFTEN BILLED	FOR OFFICE USE ONLY
			MONTHLY COST
Rent/Mortgage	\$		\$
Property Taxes	\$		\$
Insurance on Home	\$		\$
SHELTER SUBTOTAL			\$
Electricity	\$		\$
Gas	\$		\$
Oil	\$		\$
Water	\$		\$
Sewerage	\$		\$
Garbage/Trash Removal	\$		\$
Cost of Installation of Utilities	\$		\$
Other (Coal, Wood, Kerosene)	\$		\$ HCSUA
UTILITIES SUBTOTAL			\$ or \$
41A. Do you pay for utilities (separate from your rent) to heat or cool your house? [] YES [] NO			\$ or
41B. If your household is responsible for payment of utilities in addition to water, sewerage, and garbage removal, your household may qualify to choose to receive either the standard or heating utility allowance .			\$ or
			MONTHLY . TOTAL. SHELTER DATE OPTION SELECTED

42. **EXCESS MEDICAL COSTS**

Is anyone in your household 60 years of age or older, and/or certified for Federal Supplemental Security Income (SSI), Social Security Disability or Veteran's payments? [] YES [] NO If "YES", complete the following. If "NO", continue on Page 12.

Besides regularly occurring medical expenses, list those other medical services which you may have required.	Amount Paid	How Billed	Often	Monthly Total	FOR OFFICE USE ONLY
Medical and Dental Services	\$			\$	VERIFY RECEIPT OF SSI _____ FEDERAL SHARE
Hospital or Nursing Care	\$			\$	
Drugs Prescribed by a Doctor	\$			\$	
Dentures, Hearing Aids and Eye Glasses	\$			\$	
Transportation Costs to Get Medical Care	\$			\$	
Services of an Attendant or Nurse	\$			\$	
Other (Explain)	\$			\$	

			\$	SSA and SSI Listed on Page 6
42A.	List the names of household members who have these expenses:		TOTAL	

42B. Are any of the medical expenses you've listed above paid for, partially paid for or reimbursed by another source outside of your household such as medical insurance, Medicare, PAAD or another individual?
 YES NO If "YES", which expense(s) do they pay? How much do they pay?

FOR OFFICE USE ONLY

WORK FIRST NEW JERSEY AND/OR NJ SNAP WORK REGISTRATION

NAMES (ALL OVER 16)	EXEMPT WFNJ CODE	MANDATORY WFNJ DATE	VOLUNTARY WFNJ DATE	REFERRAL DATE	NJSNAP WORK EXEMPT CODE	DATE OF REG.

43. LEGALLY RESPONSIBLE RELATIVES. (THIS IS APPLICABLE FOR MEDICAID PURPOSES ONLY.)

Provide the name of your spouse if NOT in the home. Provide the name(s) of any children under 55 years of age for whom assistance is NOT being requested. If you are under 18 years of age, list your parents.

NAME	ADDRESS	RELATIONSHIP	AGE

44. HOME ENERGY ASSISTANCE

Your answer to the following question will be used to determine eligibility for Home Energy Assistance (HEA) and the amount of HEA benefits. Using the list below, indicate which item best describes your heating/living arrangement.

- () My heat is paid for by others. **(A)** HEA CODE: _____
- () My heat is provided by a public housing authority or I received a rent subsidy, and my heat is included in my rent. **(C)**
- () I pay only for a secondary source of heat (such as a wood stove, kerosene heater, electric space heater, etc.). **(E)**
- () I share the cost of heat with others. **(F)**
- () My heat is included in my rent, which is not subsidized. **(G)**
- () I pay a separate charge to my landlord for heat. **(W)**

I pay my fuel supplier directly for the primary source of heat for my house or apartment. My source of heat is:

- () fuel oil **(J)** () kerosene **(M)** () wood **(R)**

() electricity (K) () natural gas (N)
() bottled gas (L) () coal (P)

() I do not wish to receive HEA benefits. (T)

IMPORTANT NOTICE

THE INFORMATION PROVIDED ON THIS FORM WILL BE SUBJECT TO VERIFICATION BY FEDERAL, STATE AND/OR COUNTY OFFICIALS. IF ANY IS FOUND INCORRECT, YOU MAY BE DENIED NJ SNAP BENEFITS AND/OR SUBJECT TO CRIMINAL PROSECUTION FOR KNOWINGLY PROVIDING FALSE INFORMATION.

In order to comply with 45 CFR 206.10(a)(iii) and 7 CFR 273.2(b), we are notifying you that income and eligibility information for BCIS, State and local child support agencies, Social Security Wage and Benefit files, and State Wage and Unemployment files will be obtained using your Social Security Number(s) and will be used in the determination of your continuing eligibility. This may involve our contacting your employer, bank, or other party.

THE PENALTIES PROVIDED BELOW APPLY TO THE FOLLOWING:

ANY NJ SNAP RECIPIENT WHO INTENTIONALLY BREAKS ANY OF THE RULES LISTED ON THE APPLICATION; OR

ANY PERSON WHO APPLIES FOR OR RECEIVES NJ SNAP BENEFITS TO WHICH THEY ARE NOT ENTITLED BY HAVING INTENTIONALLY:

MADE A FALSE OR MISLEADING STATEMENT.

CONCEALED OR WITHHELD FACTS.

- COMMITTED ANY ACT WHICH CONSTITUTES A VIOLATION OF THE FOOD STAMP ACT, NJ SNAP PROGRAM REGULATIONS OR ANY STATE LAW RELATING TO THE USE, PRESENTATION, TRANSFER, ACQUISITION, RECEIPT OR POSSESSION OF NJ SNAP BENEFITS OR ACCESS DEVICES (SUCH AS FAMILIES FIRST EBT CARDS).

PENALTIES

THE FOREGOING VIOLATIONS CAN RESULT IN THE INDIVIDUAL BEING BARRED FROM PARTICIPATION OR FURTHER PARTICIPATION IN THE NJ SNAP PROGRAM AS FOLLOWS:

FIRST VIOLATION - *12 MONTHS

SECOND VIOLATION - *24 MONTHS

THIRD VIOLATION - PERMANENT DISQUALIFICATION

*AN ADDITIONAL 18 MONTHS SUSPENSION (CONSECUTIVE TO THIS PERIOD) MAY BE IMPOSED BY THE COURT FOR ANY PERSON CONVICTED OF FELONY OR MISDEMEANOR VIOLATION.

THE VIOLATOR MAY BE FINED UP TO \$250,000, IMPRISONED UP TO 20 YEARS, OR BOTH, AND SUBJECT TO PROSECUTION UNDER OTHER APPLICABLE FEDERAL LAWS.

IN ADDITION, THE REMAINING HOUSEHOLD MEMBERS WILL BE REQUIRED TO REPAY ANY NJ SNAP BENEFITS THE HOUSEHOLD RECEIVED TO WHICH IT WAS NOT ENTITLED.

P.L. 103-66 AND 104-193 ESTABLISHED PENALTIES FOR INDIVIDUALS WHO ARE FOUND GUILTY IN A FEDERAL, STATE, OR LOCAL COURT OF:

- 1) TRADING NJSNAP BENEFITS FOR FIREARMS, AMMUNITION, EXPLOSIVES, OR CONTROLLED SUBSTANCES; OR
- 2) USING, TRANSFERRING, ACQUIRING, OR POSSESSING NJ SNAP BENEFITS, THROUGH THE USE OF FAMILIES FIRST EBT CARDS, OR PRESENTING NJ SNAP BENEFITS FOR PAYMENT KNOWING SAME TO HAVE BEEN FRAUDULENTLY OBTAINED OR TRANSFERRED, IF THE VALUE IS \$500 OR MORE.

EFFECTIVE SEPTEMBER 22, 1996, INDIVIDUALS DETERMINED BY A COURT OF APPROPRIATE JURISDICTION TO HAVE COMMITTED THOSE PROGRAM VIOLATIONS WILL BE SUBJECT TO:

OTHER PENALTIES (cont.)

■PERMANENT DISQUALIFICATION FROM THE NJ SNAP PROGRAM

ALSO, AN INDIVIDUAL FOUND BY A COURT OF APPROPRIATE JURISDICTION TO HAVE WILLFULLY MADE FRAUDULENT STATEMENTS IN ORDER TO OBTAIN NJ SNAP BENEFITS FROM MORE THAN ONE JURISDICTION CONCURRENTLY SHALL BE:

■ DISQUALIFIED FOR 10 YEARS FROM THE NJ SNAP PROGRAM.

PENALTY WARNING

DON'T give false information, or hide information, in order to apply for or receive or continue to receive NJ SNAP benefits.

DON'T give or sell NJ SNAP benefits or access through the use of Families First EBT cards to anyone who is not authorized to use them for your household.

DON'T use any NJ SNAP benefits to buy ineligible items, such as alcoholic drinks and tobacco.

DON'T use any NJ SNAP benefits your household was not entitled to receive.

DON'T cheat or take part in any dishonest act to get NJ SNAP benefits your household isn't entitled to receive.

DON'T transfer resources to a non-household member in order to apply for and receive NJ SNAP benefits.

I understand the questions on this application. My answers are correct and complete to the best of my knowledge and belief. I understand that I must be interviewed, and that I must cooperate with the NJ SNAP office. I understand the penalty warning. I understand that I may have to provide documents to prove what I've said. I agree to do this. If documents are not available, I agree to give the name of a person or organization the NJ SNAP office may contact to obtain the necessary proof. I understand that if I have not reported any earned income, then I must report any change in unearned income of more than \$50.00, or the receipt of earned income within 10 days of the date of my first paycheck. I understand that if I have no earned income, I must report all changes in household composition (including student status), changes in residence and the resulting change in shelter costs, changes in my legal obligation to pay or provide child support, a change in the amount of child support I provide if I have less than a 3-month record of paying it and the change is greater than \$50.00, a purchase of a vehicle or an increase in my household's resources (savings and checking account, cash on hand, stocks or lump sum payments, any cash deriving from the sale or trade of a vehicle) if they reach or exceed my maximum resource limit. I understand that if I reported earned income, or I am on a six-month reporting, I am only required to report a change in my monthly total income that exceeds 130 percent of the federal poverty level limit. My worker will provide me with a notice of that limit. I also understand that I may request a fair hearing of the decision made on my application for NJ SNAP benefits. If I need more information concerning NJ SNAP benefits, I can contact the county NJ SNAP office.

I understand that I, or my representative, may request a fair hearing, either orally or in writing, if I disagree with any action taken on my case. My case may be presented at the hearing by any person I choose.

U.S. CITIZENSHIP/LEGAL ALIEN STATUS
(FOR WFNJ, MEDICAID AND NJ SNAP PROGRAM PURPOSES)

For each person who is not a U.S. citizen, you will need to show the county welfare agency office either documentation from the Bureau of Citizenship and Immigration Service (BCIS) or other documents the State agency determines are proof of your immigration status. Alien status may be subject to verification with the BCIS which will require submission of certain information from this application form to the BCIS. Information received from the BCIS may affect your household's eligibility and level of benefits. You must certify that each household member is a U.S. citizen or is living in the U.S. in lawful immigration status.

BEFORE YOU SIGN, READ THE STATEMENTS BELOW. IF YOU DO NOT UNDERSTAND OR HAVE ANY QUESTIONS, PLEASE ASK.

*I (we) agree that the statements that I (we) made on this form are true and complete to the best of my (our) knowledge. I (we) know that lying about my (our) situation, failing to give the necessary information or causing others to hold back information is against the law and may subject me (us) to prosecution.

*I (we) understand that any information I (we) give is subject to verification by the County Welfare Agency, and/or the Division of Family Development and/or the Division of Medical Assistance and Health Services.

*I (we) hereby authorize the County Welfare Agency, Division of Family Development and/or the Division of Medical Assistance and Health Services to contact any individual or other source who may have knowledge about my (our) circumstances (to include IRS, State and local child support agencies, Social Security Wage and Benefit files, State Wage and Unemployment files, credit reporting services, as well as employers, banks or other parties) for the sole purpose of verifying the statements I (we) have made. I (we) understand that any income and eligibility information obtained will be used to determine my (our) continuing eligibility.

*I (we) understand that, in accordance with Work First New Jersey Act, Public Law 1997 c.13, c.14, c.37 and c.38, application for public assistance will include all future members of the budget unit required to be included, whether by birth, adoption, or by beginning to live with the budget unit after the date of the original application.

*I (we) know that any information I (we) give will be used in connection with my (our) application for public assistance (including Medicaid), NJ SNAP benefits, home energy assistance benefits, Universal Service Fund benefits and other benefits for which I may be eligible.

*I (we) understand that if this application is accepted for the WFNJ category, that I (we) and all members of my (our) household are enrolled in the New Jersey One Stop Career Center and may be required to participate in education, training, vocational assessment and job placement activities.

*I (we) understand that all home energy assistance payments are subject to the availability of federal funds.

*I (we) understand that all home energy assistance payments made are to be used toward the purchase of heating/cooling energy.

*I (we) have received and had explained to me (us), if necessary, information concerning my rights and responsibilities. (See WFNJ Handbook concerning my rights and responsibilities.)

*I (we) agree to let the County Welfare Agency know immediately of any change in living conditions, family situation or money received (except for earned income that is subject to six-month reporting requirements) from any source, when applicable. (See WFNJ Handbook.)

*I (we) understand that I (we) or my (our) representative may request a fair hearing, either orally or in writing, if I (we) am (are) not satisfied with any action taken by the County Welfare Agency. My (our) case may be presented at the hearing by any person I (we) choose.

*I (we) understand that upon signing this application for WFNJ and Medicaid purposes only, I (we) assign to the County Welfare Agency any right to support, including any arrears that have accrued, from any other person for myself or any other family member for whom I (we) am(are) applying for or receiving aid.

*I (we) understand that as a condition of eligibility for medical assistance, it is deemed that I (we) have assigned to the Commissioner any rights to support for the purpose of medical care as determined by a court or administrative order and any rights to payment for medical care from any third party.

*In accordance with Federal law and U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. Under the Food Stamp Act and USDA policy, discrimination is prohibited also on the basis of religion or political beliefs. Discrimination complaints may be filed in writing to:

HHS, Director
Office of Civil Rights
Federal Building
26 Federal Plaza
New York, New York 10007

OR
USDA, Director
Office of Civil Rights
Whitten Building, Rm. 326-W
1400 Independence Ave. SW
Washington, D.C. 20250- 9410

OR
Office of the Director
Division of Family Development
New Jersey Department of Human Services
P.O. Box 716
Trenton, New Jersey 08625

**COMPLETE
BEFORE
SIGNING**

I (WE) have read the Important Notice on Page 10 of this form referring to the NJ SNAP penalty warnings and Citizenship/Legal Alien Status. () YES () NO

*I (we) attest that I (we) have read and agree to these statements and fully realize that the Welfare Agency relies upon the truth and accuracy of my (our) statements.

*I (we) certify, under penalty of perjury, by signing my (our) name(s) below, that I (we) and all household members for whom I (we) am (are) applying for NJ SNAP benefits are U.S. citizens or aliens in lawful immigration status.

*I (we) certify under penalty of perjury that my (our) answers regarding application for the NJ SNAP Program and/or the WFNJ program are correct and complete, to the best of my (our) knowledge.

*I (we) have received an orientation to the WFNJ work requirements by the agency representative, if applicable.

SWORN AND SUBSCRIBED BEFORE ME

Applicant Signature Date

This _____ Day _____ 2____

Co-Applicant Signature Date

(Agency Representative)

**IMPORTANT NOTICE
NJ SNAP INCOME DEDUCTION WAIVER**

IF YOU FAIL TO REPORT OR VERIFY ANY OF THE FOLLOWING EXPENSES WHICH EITHER YOU OR ANOTHER HOUSEHOLD MEMBER IS PAYING, WE WILL TAKE THIS TO MEAN THAT YOU DO NOT WANT TO RECEIVE AN INCOME DEDUCTION FOR THOSE UNREPORTED EXPENSES.

- A DEPENDENT CARE EXPENSE, IF YOU ARE PAYING FOR THE CARE OF A CHILD OR OTHER DEPENDENT SO THAT A HOUSEHOLD MEMBER CAN WORK, SEEK EMPLOYMENT, OR ATTEND TRAINING OR EDUCATION CLASSES IN ORDER TO PREPARE FOR EMPLOYMENT;
- AN UNREIMBURSED MEDICAL OR DENTAL EXPENSE, INCLUDING PRESCRIBED MEDICATION, HEALTH OR HOSPITALIZATION INSURANCE, EYE GLASSES, OR ATTENDANT CARE;
- A CHILD SUPPORT PAYMENT WHICH A HOUSEHOLD MEMBER IS MAKING UNDER A LEGAL OBLIGATION, INCLUDING PAYMENTS ON ARREARS; OR
- A SHELTER EXPENSE, SUCH AS RENT, UTILITIES (INCLUDING INSTALLATION CHARGES), PROPERTY TAXES, HOMEOWNER’S INSURANCE, AND CHARGES FOR REPAIR OF YOUR HOME DUE TO A NATURAL DISASTER.

EVEN IF YOU DO NOT TELL US (OR VERIFY) THAT YOU ARE INCURRING ONE OF THESE EXPENSES WHEN YOU APPLY FOR NJ SNAP, YOU MAY STILL RECEIVE AN INCOME DEDUCTION LATER IF YOU TELL US (OR VERIFY) THAT YOU ARE PAYING ONE OF THESE EXPENSES. THE DEDUCTION WILL NOT BE RETROACTIVE FOR THOSE MONTHS THAT YOU DID NOT TELL US THAT YOU WERE PAYING THE EXPENSES.

HEAD OF HOUSEHOLD SIGNATURE

TODAY'S DATE
